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ABSTRACT

The phenomena of fusion within a lesbian relationship is described in a six-phased model. Fusion in relationships is defined as two incomplete people coming together in an attempt to make one more complete whole, the merging of two ego boundaries. The six phases discussed include ecstacy, getting married, the routine, depression/withdrawal, pulling apart/conflict, and ecstacy, again. Attention is focused on clinical considerations and therapeutic interventions. There is discussion of norms within the lesbian subculture that reinforce unhealthy patterns, diagnostic concerns, special treatment concerns when working with gay clients' and innovative treatment strategies. Clinical case examples highlighting both the dysfunctional aspects of these relationships as well as the potential for healthy outcomes for the women and/or the relationship are discussed. The paper contends that approaching the treatment with certain assumptions of health and potential for growth may allow many couples to have the opportunity to flourish individually while remaining with their lover. It concludes that, regardless of how long a couple remains in treatment, the therapist has an important opportunity to educate the women about their potential for mental health. (ABL)

WORKING WITH FUSION IN LESBIAN COUPLES

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ABSTRACT: The phenomena of fusion within a lesbian relationship is described in a six phased model. Attention is focused on clinical considerations and therapeutic interventions. There is discussion of norms within the lesbian subculture that reinforce unhealthy patterns, diagnostic assessment concerns, special treatment concerns when working with gay clients and innovative treatment strategies. The author offers clinical case examples to highlight both the dysfunctional aspects of these relationships as well as the potential for healthy outcomes for the women and/or the relationship.

PREFACE

Before I begin, I would like to make a few critical preface remarks. They concern my attitude in working with lesbians and the homosexual culture in general. These are considerations that I feel any therapist must deal with before ever agreeing to work with any gay clients.

First of all, the sexual orientation of these clients is not a treatment concern. I make the assumption, unless I'm told otherwise, that these women are comfortable with their choices to live a gay life style. I do not view that choice, in and of itself, as the problem or cause to look for pathology. My concern in the treatment is focusing on relational problems that the couple presents to me. We are dealing with how to have a healthy and satisfying relationship, period.

Secondly, I feel that it is ethically irresponsible of any therapist to agree to see gay clients without first confronting his/her own homophobia. It is not enough to be a "good liberal" in this work because there are subtle negativities that can sabotage the work and ultimately hurt the couple. Each therapist ought to do some self exploration on these issues as well as be very informed about your gay community and its overt and covert norms. The best way to do this is to talk to as many gay people as possible and to attend any trainings in your area. Speaking with other therapists who are known for their work with gay clients would be extremely useful.

Being a social psychologist at heart, when I work with lesbians and gay men I take a multi-cultural perspective. The mega-strata is the larger heterosexual and homophobic society within which we all exist. I integrate this with the smaller subculture of the gay community--focusing on its own set of norms and mores. Finally I must bring in the perspective of each person's family of origin. In particular I am concerned with the family's response to my client's homosexuality and the family or ethnic reaction to this situation. In addition, I look extensively at family of origin issues just as I would for any client.

It is critical to view the gay population as an oppressed minority and take that into account when dealing with individuals or couples. Without this assumption, the subtleties of homophobia can further oppress the couple and jeopardize successful treatment.

Lastly, I would like to offer my own working definition for fusion. In its simplest terms I would define fusion in relationships as two incomplete people coming together in an attempt to make one more complete whole. It is the merging of ego boundaries of two people who have not established firm individual ego intactness on their own. The fusion relieves anxiety that accompanies that incompleteness. Do not confuse this with borderline personality disorders. That is quite another matter. I am speaking here of individuals who have not been successful at separation and individuation tasks up to this point but who clearly demonstrate the capacity to accomplish those developmental tasks.

What follows, then, is a six staged model of the development of these fused lesbian relationships and recommendations for treatment that would allow each women to successfully individuate while learning

how to be in a healthy intimate relationship.

PHASE ONE: ECSTACY

"It has never been this good before.."
"I've never let anyone know me so well.."
"...feels like we've known each other forever.."
"I just can't stop thinking about you...want to be with you all the time.."
"This will definitely last forever."

The beginning of a fused relationship is filled with sexual and emotional intensity. A euphoric bonding occurs that feels like "the answer" each woman has been searching for. Lovemaking is frequent, uninhibited and focal point of the developing relationship. Because the sexual encounters are so open and satisfying there is a pseudo-intimacy that gets labeled "love" or "being in love". Both women obsess about each other when they are apart and separations can often feel "painful"--filled with longing. This "pain from separation" also becomes defined as love. To cope with this emptiness that sets in, the couple spends minimal time apart.

During this early phase there are many negative comments offered about the previous lovers each woman most recently left. "She never made me feel this safe/happy/loved/turned-on.." "You're so warm and affectionate. She was so cold and distant." Basically, both women are questing for the opposite of the lost love relationship--blaming the pain of the separation on the ex-lover's flaws. There is a great deal of reacting occurring in each woman and, as Betty Carter has said, "The exact opposite is exactly the same." There has been no working through of any issues; no self-reflection. There is simply a move to be free of pain and loss. This "ecstacy phase" with a new lover provides an intensely good feeling and much togetherness. Both women conclude that it is this new woman who is the "perfect match" so now everything will be just fine.

The major components of this initial phase of the new relationship are sexual intensity, obsessional thinking, dropping back from activities/relationships that take the women away from each other, pseudo-intimacy and relief from pain, loss and separation. This will generally last for 1-6 months.

PHASE TWO: GETTING MARRIED

"You are my spiritual soulmate.."
"We're with each other all the time anyway...let's live together"
"Let's open a joint checking account..plan for our future.."

While in this heightened state of emotional and sexual merging, the couple will often decide to get "married". Within the lesbian community this could manifest in a variety of ways. The couple could have a symbolic wedding ceremony either privately or communally complete with the exchange of rings. They may decide to live together

or open a joint checking account or invest in the purchase of a home. Power of attorney papers may be drawn up or furniture may be bought together. Any or all of these actions represent the commitment the women have to each other and their future together. They are still in very high gear in this phase as they move towards nesting.

The denial that is operative in this phase is that binding their lives together will insure ecstacy and constant togetherness. Even though past experiences would lead each to the conclusion that the intensity of "falling in love" usually fades, each woman is blinded by the present good feelings and assumes it will continue this time because she has finally found the right partner. What motivates this illusion and subsequent denial is the fear of separation/loss. Many couples will actually openly discuss this with each other--how they are terrified of being abandoned. By "getting married" so early on each woman is pledging to "never leave". "I'm not like your past lovers. I see the real you and I love you deeply and would never leave you." The partner will oblige with a similar vow. This is the beginning of anxieties creeping into each woman that they forcibly set aside. They become doubtful that either one can truly fulfill this total commitment. Part of them can sense the fantasy of such a promise. This anxiety often gets reinterpreted as the fear that accompanies making a serious commitment and therefore something to just swallow so one can take the plunge.

These marriages are generally sanctioned within the lesbian community and there is a certain amount of respect offered to the boundaries around this couple at this point in its development. All this usually occurs 4-10 months into the relationship.

PHASE THREE: THE ROUTINE

"Friday night is for making love. We always sleep late in Saturdays.."

"Jane doesn't like parties so we never go to any..."

"I like to cook, she prefers to pay the bills.."

"Sally is just shy/anxious/depressed...She's really wonderful when you get to know her..."

"We always....we never..."

With security and fears of abandonment as the underlying motivation, the couple will usually establish an overly rigid routine. Their lives become ritualized and spontaneity seems to threaten their bond. If one woman is asked to go for a Saturday afternoon bike ride with a friend she will usually say No or invite her lover along. She wouldn't want her lover to feel left or left out. This kind of decision making is typical in fused relationships and leads to a narrowing of possibilities and choices for each woman. Over a period of time, daily and weekly expectations become very clear. Wednesdays and weekends are for lovemaking, Tuesdays are for shopping, Friday nights are dinner out, etc... When other options present themselves it can create conflict in the relationship if it gets seriously considered. For instance, if friends invite the couple to an early

movie on Friday but that is their time to eat out, the couple can simply turn down the offer (choosing security) or they can grapple with changing the rule. The degree of fusion will usually determine the response in these situations.

Another part of the routine that develops is role assignment. At this point, strengths, weaknesses, skills and insecurities have been identified. The women move to protect each other from fears and weak spots and to nurture abilities and strengths. A rigidification of roles is the end result. Remember, all this is to make the relationship safe--to waylay fears of separation. So if one woman loves to dance and the other feels awkward and self-conscious, the first woman will move to protect her lover by giving up her wish to dance. Be forewarned! These losses of one's identity resurface later in this relationship and become serious points of conflict.

The sexual lustre has faded considerably by now for this couple. Experimentation and openness have dropped off and lovemaking as become routine and far less frequent. Each woman has some concern about this but they are convinced this will pass and the fires will be reignited. Besides, there is the job/illness/stress/money/parents....more denial, more delusions. At this point, the couple has been together for 8-12 months.

PHASE FOUR: DEPRESSION/WITHDRAWAL

"You never want to make love anymore...makes me feel abandoned/rejected/alone/unloved/panicked..."
"We never talk anymore.."
"It's not you...it's just this thing I'm going through.."
"I really do love you...just don't feel sexual these days.."

As the routine persists and as each woman becomes less capable of dealing with any amount of change and as each woman becomes less complete and competent on her own, depression sets in. The pattern that has been in motion leads to individual and relational dysfunction. Because so many ego boundaries have been blended, neither woman can adequately exist separately. What was once a fact that created exhilaration now creates inertia and panic. The paradox is that they look to each other to be more functional to end this frightening void. The most common demonstration of this breakdown is in the sexual relationship. One of the women will feign "lack of sexual motivation/stress/stuff I'm going through..." and pull away sexually. The other woman will insist that she is "sexually frustrated/unsatisfied/feels unattractive and rejected..." by all of this. The stance that develops (again, rigid roles) is that one woman is "undersexed" and the other woman is "oversexed" and a stalemate occurs. The couple becomes asexual by a covert agreement and periodic overt disagreements. The "oversexed" lover tries to protect her lover's frailties by being understanding and thus cooperates in the standoff. The illusion is created, however, that only the "undersexed" lover has a problem. This makes the couple feel off-balanced and dysfunctional. But to confront the multiple issues present in this relationship would mean bursting the fantasy of this perfect,

everlasting union.

This phase lasts longer than any other. It is where fused couples can get terminally stuck because it becomes predictable and very secure--even if it feels awful. Some couples can stay at this point for years because on the other side of this dilemma is pain and ego separation--the most dreaded and feared challenges. This is often the time when individual or couples therapy is pursued.

PHASE FIVE: PULLING APART/CONFLICT

"I'm just not in love with you anymore..."
"I'm not sexually attracted to you anymore.."
"You're just like my ___(bad parent)_____"
"You just don't understand me...only my ex-lover really knows me."
"I just can't get my needs met here.."

If there is enough ego intactness in one of the women, the couple will move towards overt conflict. This usually takes the form of verbal (or physical, in extreme cases) fighting, constant tension or hostility, more extreme polarization on most issues ("I always...you never.."), blaming the other for the problems and a pulling away from the relationship. Without some ego boundaries, there can be no outrage at the situation. If the couple reaches this point in the relationship this usually signifies the beginning of the end--which both women suspect is the case.

The content of many of the arguments will be all the negative things neither woman has expressed about the other so far in the relationship. It surpasses merely a breakdown of the denial--it moves to the extreme negative side of the polarization. This is the couple's attempt to reestablish ego boundaries they have given up. Often one woman will appear more hostile or aggressive and the other will be more passive or wounded. Be assured that they are both participating in the dissention. Ex-lovers are miraculously resurrected as "goddesses" and the new lover has taken on the role of the "uncaring bitch". Solace is sought with ex-lovers, creating more open conflict between the women.

By now the relationship is completely asexual. This is a very clever way that fused lesbians try to draw clear and intact boundaries around themselves. In some ways it is a healthy indication that some separation is desirable. In other ways, it is an extreme position that keeps the relationship dysfunctional.

Although some ambivalence is present in each woman that can create a cycle of pulling away and coming together again, somewhere inside one or both women a decision has already been made to leave the relationship. This open aggression is the method the couple uses to disrupt the merging. Triangulation with past or new lovers is the other common "solution" the women will use to pull apart. If there are not enough internalized ego strengths, each woman will need to bond to someone else to feel complete enough to leave this now imperfect lover. Again, loss and the pain of separation must be avoided and a new lover can provide the necessary protection. This sets the stage for the

recycling through these phases with a new person. The challenge of individuation, acceptance of autonomy/separation and an opportunity for self-awareness and self-reflection can be circumvented once again. And so it goes...

PHASE SIX: ECSTACY, AGAIN

"I've never felt this good before.."
"...so glad I left her...been dead for so long.."
"I used to all the giving with her...so wonderful to take with you."

Usually, without skipping a beat, each woman will begin a new relationship with many of the same dynamics as the previous one. Although each woman may vow that she is not ready for another relationship, she seems to "just fall into" this new romance. As if inertia sucks them into it, the enmeshment begins all over again. The new lover may be on the scene already or it might have started as a fling. Euphoria begins to mask the pain and self doubts left over from the previous lover and defenses are rebuilt. No growth or insight has occurred for either woman. This new lover becomes "the one I've been looking for all my life..."

NORMS WITHIN THE LESBIAN SUBCULTURE THAT RE-INFORCE THIS CYCLE

An understanding of the norms within the lesbian subculture illuminates some of the reason why there is a propensity towards this kind of fusion for some women. Many of the characteristics of these relationships are perceived as normal, acceptable and even admirable among some lesbians.

There exists for women, homosexual or heterosexual, the reluctance to label strong sexual attractions as purely sexual feelings. Women need to attribute emotional closeness or love to the expression of strong sexual desires. What is actually lust or sexual desire gets relabeled as love or intimacy. Love takes time and sharing to develop yet women will be convinced that the strong feelings they feel for each other are "true love". This unfortunate inaccuracy implies greater depth and commitment than is possible so it sets the tone for a premature bonding.

Among many lesbians there is a commonly held belief that the ideal love relationship is one that resembles Phase one of this cycle. That intense rapture is acceptable, desirable and even enviable. Peers would not offer much challenge to a friend's pledge of quick and deep love for another woman. There would be nothing strange about this.

There are three options for fidelity among lesbians. Complete monogamy is the choice of many "married" couples. Non-monogamy is popular among a segment of the community which sanctions more than one lover or one primary lover and other less important sexual partners. Serial monogamy is most often discussed in the literature as the most

common pattern among lesbians. Serial monogamy without any time off in between relationships can lend itself very easily to this pattern of cyclical fusion. This avoidance of singlehood is often a good indication of a likely candidate for a fused relationship.

Because there are no legal or societal sanctions for a lesbian couple it is often difficult for the couples' boundaries to be respected within the gay community. Unless the women make it very clear that they are completely monogamous, other women will continue to flirt or perceive the women as "fair game". If the situation becomes too difficult, the couple may need to withdraw from lesbian activities in order to preserve their relationship. This imposes isolation for the couple that reinforces their own little fused world. In later stages of the fusion cycle these same women may begin to socialize again in the hopes of experiencing an "innocent flirtation". These flirtations may turn into more serious intentions and thus, complete the cycle.

One explanation for the fused couple remaining in the fourth phase, Depression, for so long is the need among lesbians to have role models of long term relationships. Many women will lament that if they "don't stay together everyone else will lose faith that it's possible for a lesbian relationship to last". Of course, heterosexual relationships don't have much staying power anymore either but they still have acceptance from the larger culture and therefore more support to work it out. When a lesbian couple has struggled through family, peer and co-worker reactions to their relationship to attain a certain level of acceptance, there is some understandable reluctance to undo all that work and start all over again. So there are subtle pressures within the lesbian community as a reaction to the homophobic culture-at-large that encourage a faltering couple to stay together.

For those couples that still ascribe to the old butch/femme standards for their relationships, the rigidification that is characteristic of fused couples will be reinforced by some segment of the gay community. There would be no open challenge to the polarizations of roles that gets established for the couple. If anything, the role assignments will be used to justify someone's behavior. "Oh, she's just so weepy because she's such a femme..."

ASSESSMENT CONCERNS

When the couple first presents for treatment there are several issues you need to be particularly alert about. What follows is a list of seven diagnostic markers that will help with treatment planning for the couple.

1. Which phase of the cycle is the couple in. Listen for clues about polarizations, blaming, rigidity and affective and non-verbal cues. What are their treatment goals? Are they in agreement about the goals? Are they in your office for marital or divorce treatment?

2. How does the fusion work? Who plays which roles? What are the two halves making the one whole? How does the complimentarity play itself out? How intense is the fusion? Can they be separate at all? Can they have separate opinions? Do they always speak for each other?

3. Take a brief history of the relationship. Especially find out about the beginning of the relationship. How quickly did they become intensely involved and how long have they been together at the time of treatment. Were one or both women involved or just breaking up from other relationships? What unresolved losses were present at the onset of this relationship?

4. Take a family of origin history for each woman. In particular, look for the following: what role did each play in their families; what early losses/narcissistic wounds/insufficient bonding occurred; were either women in a fused relationship to a parent; is there a history of alcoholism or severe depression in either family?

5. Assess for substance abuse. Are there alcoholic-enabler dynamics present in this relationship? (If there are substance abuse concerns, those must be dealt with before treatment can proceed.)

6. What is their connectedness to the lesbian community? Do they have separate friends or only mutual ones? Do they spend time with other lesbian couples? Are single lesbians viewed as a threat to their relationship? In what parts of their lives have they "come out"? Do they involve themselves in activities outside of the gay community?

7. Sketch out an eco-map of their relationship. Diagram the intersecting points so that the extent of the fusion can be determined. What resources are missing and where are the stressors?

SPECIAL TREATMENT CONSIDERATIONS

Because of the unique interweaving of the three stratum of the larger heterosexual culture, the gay subculture and the family of origin context there are several ways in which treatment with fused lesbian couples is different than working with a similarly fused heterosexual couple. In mapping out a treatment plan keep in mind the following recommendations. Be very sure that you understand what you are getting into before you agree to treat the couple.

Because lesbians have had to entertain a fair amount of introspection in order to acknowledge and accept their homosexuality, they often enter treatment with a degree of psychological savvy. They are also extremely sensitive to homophobic reactions in others (gay or straight). These two things together make them shrewd consumers during the first assessment sessions with you. Because of this (if you don't already make a habit of this with all clients), make your treatment bias known right away. Identify your awareness of gay concerns and the alternate structure of lesbian relationships. Make it clear that being gay or straight has nothing to do with establishing and maintaining healthy relationships. Offer your sense of what you consider a healthy relationship and what kind of work it takes to have one. Some women may challenge your credentials and question your political consciousness. Do not enter into political debates or else you run the risk of constantly proving your political correctness and thus sidetracking yourself and the couple in the treatment. You may also be offered elaborate psychological analyses of the lover's problems during these sessions. The couple will try very hard early on to pull you into their collusive dynamics. As in all couples work, resist the

temptation to agree with their assessment of their problems. The polarizations will be so intense during their presentation that you will surely perceive one as much more healthy than the other. You may even entertain the possibility in your mind of individual treatment for only one of the women. Do not bite the bait! All chances for success will be lost if you do. Because of their astuteness when they enter treatment you may be fooled into their debates and psychological assessments. From the beginning you must set the stage for each woman to become responsible for her part in the problems and begin the process of individuation. State your observations about their collusion in the troubles right away without leaving it open for denials and defenses. If worse comes to worse, they will seek out another therapist--one who will buy into the fusion.

Find out as much as you can about your gay community and their connectedness to it. If you discover that there is a lack of respect for privacy or boundaries--that everyone knows everyone else's business--the harder your job is going to be. It may be that this couple has no idea that they have spun into an unhealthy pattern because "everyone else's relationship looks just like ours". In this case you will need to do some teaching about the difference between friendships, flirtations, primary relationships and what is appropriate in each of them. Keep in mind that you do not want to cut these women off from lesbian support but you want them to seek out those women who can support greater individuality.

As the couple develops more separate activities and identities, ex-lovers often play a critical role. They are usually a source of great tension, jealousy and conflict in the primary relationship because the ex-lovers still have such a presence in their lives since no work was done to end those relationships. If there has been enough time or healing from the past that has occurred, ex-lovers can play a very important and helpful role in these cases. Since lesbians often create their own "chosen families" as a solution to their needs for connectedness that being gay may have eliminated for them, ex-lovers may eventually become "family members". If there are clear and appropriate boundaries with the ex-lover that would not create a triangulation, you may want to support and encourage their friendship. If this is not possible and their enmeshment is still operating, then this needs to be confronted in the treatment.

You as the therapist will play a key role in the process of individuation. If there are few resources at the beginning of treatment for either woman to rely on, you may have to play a more active or prominent role than usual. It will be important to model clear boundaries and separate relationships to each woman. In some cases you may need to work individually as well as conjointly. Confidentiality becomes even more critical than usual and no information should be shared with the other woman. Make this a clear verbal contract from the beginning. For each woman to experience a private relationship that does not get shared with the lover will be very meaningful. In extremely fused couples it may be necessary to engage the help of another therapist who will work individually with one of the women. Whenever possible, however, it works best to be the only therapist involved for two major reasons. One is that you will

have more clarity about how the fusion works and, secondly, you have the opportunity to model separate relationships which will aid the process of individuation.

If the couple presents for treatment and you have assessed that they are in Phase Five; Conflict you need to accept that they will be likely to leave treatment within a very short time. Basically, treatment at this point is the last gasp of breath before the breakup and they simply want external permission. If they present at Phase Four; Depression, however, the prognosis improves considerably.

Be as creative as possible in your interventions during the course of treatment. Remember that these women are used to alternative and creative solutions to complicated problems. Be active during strategy sessions with them and have a little fun with it. Whenever possible, use humor and the absurd. This helps them to gain perspective on their rigidity. Listed below are some clinical interventions that can prove to be particularly useful.

Reframing. Because of the intensity the fusion can create, breaking through the denial and collusion can be especially challenging for the therapist. Reframing is the most powerful intervention for redefining what is occurring for each woman. For example, "I just miss her so much when we're apart. It feels so unbearable" can be fed back to the client as "So being alone is intolerable to you". Or the expression, "We're so attracted to each other--you know, it's so deep--spiritual really" can be reframed as "In other words, your sexual attraction for each other is very intense". Reframing gives you many opportunities to clarify the difference between sex and love, intensity and obsession, desire and anxiety and intimacy and lust.

Cognitive approaches. In order to individuate, these women basically need to learn to enjoy being separate with other people or alone. What will inevitably be present as they begin to learn how to establish boundaries is anxiety and panic. Using cognitive interventions can teach the women what separateness means and give them some concrete solutions for dealing with the ensuing anxiety attack. Explaining that the anxiety attack is not because she is so in love and cannot stand to be without her lover can be a helpful first step. Discuss the healthy reasons why separations will help their relationship; that the pressure of always being together will blow up in their faces and create the end of their relationship, for sure. Give them specific instructions for riding out the waves of panic such as: calling a friend, relaxing with a book or TV or music or bath, talking to self remembering that she will survive the panic, do not wait up for the lover or interrogate her for every little detail about her time apart. Give the couple a chance to describe what the time apart does NOT mean such as abandonment or an opportunity to have a sexual fling.

Behavioral contracting. Either verbally or written, strategize with the couple to agree to change certain behaviors. Get their mutual consent to a series of plans that would allow for greater separateness. Examples of this would be: reduce the number of phone calls they exchange during the day, sign up for separate athletic or social activities, agree to lift the "ban" on certain exclusive activities (ie. dancing, movies), give each other permission to make spontaneous

decisions that would not include the lover without fear of punishment.

Unbalancing the complimentarity. An effective way to loosen up the role rigidity is to suggest role reversals. If one woman is always the approacher, suggest that she lay low and not pursue her lover. Likewise, recommend that the other woman be active in pursuing her lover. They will protest over these exchanges but be persistent. Pick a low risk reversal to start with and then gradual escalate. Although the couple is usually asexual at this point, a "No Sex" contract with them can be just paradoxical enough that it stirs something up. Shuffling the role assignments is an area where you and the couple can have some fun. Make it as playful as possible.

CASE EXAMPLE #1

Darlene phoned me shortly after she and her lover, Natalie, had been at a workshop I had presented on Lesbian Relationships. She inquired about individual treatment because she was feeling very depressed for quite some time now. She had been putting off therapy but Natalie was getting more insistent that Darlene be in treatment.

Darlene is 29 years old and is a patient representative at a local hospital. Natalie, 31 years old, is a social worker at the same hospital. They have been together for 3 years and neither were in a serious relationship when they first got together. They had been very much in love with each other for 2 years and had bought a house together. They felt safe to come out at work and in their families and they get a good deal of acceptance from co-workers and family members. They have a handful of lesbian couples they spend time with and both play softball on the same team. For the past year, Darlene has been withdrawn, uncommunicative and rarely sexual.

Early individual sessions with Darlene reveal that she has no idea why she feels so depressed. Things are really alright at work and at home but she's just "tired" of this relationship with Natalie. She describes being a very reserved person who has difficulty articulating her thoughts. This is apparent in her presentation. She has great difficulty identifying any feelings. She comes from a family of three children of whom she is the oldest. Her father died of alcohol-related illnesses when she was 14 years old and her mother is a nurse who is an active alcoholic. She and her brother and sister are worried about their mother. Darlene and her sister were sexually molested by their grandfather for several years during her childhood while he lived with her family. The incest stopped with his death when Darlene was 11 years old. Her current stance is that her mother was a wonderful mother and still is and that she had loved her father dearly when she was small, before the heaviest drinking. She has never considered the possibility that her early childhood may have left any emotional scarring. She assumes it was a better-than-most early life.

Initially I put aside questions about her current relationship with Natalie because there was no impending crisis that needed our attention. So we began work on Darlene's family of origin. Work proceeded somewhat slowly but as expected. Her denial system was

extremely intact and took some time to break through. She made good progress in the treatment.

Meanwhile, Natalie is getting impatient. She writes me several letters "to be helpful with Darlene's therapy" explaining her point of view about Darlene's problems. I did not respond to any of the letters nor reveal to Darlene that I had received them. Unexpectedly, Natalie was diagnosed with cervical cancer. The prognosis is good and the surgery will be minor. Darlene feels fairly unresponsive to the situation but promises to stand by her lover and take care of her. The lack of affect from her lover prompts Natalie to call me to begin her own individual therapy with me. There is now a crisis in the relationship. Natalie's worst fears are that Darlene doesn't lover her and will leave her at her moment of greatest need. She presents this in a very intellectualized form describing the acute nature of Darlene's depression. Meanwhile, Natalie is feeling panicked.

Early individual sessions with Natalie reveal that her mother is a recovered alcoholic and has had a series of major operations and health problems throughout Natalie's childhood. She has angry and resentful feelings towards her mother and struggles to find a decent relationship to her now as an adult. Her father died four years ago of a heart attack and Natalie feels she lost the only person she had any connection to in her family. There are 4 brothers and 1 sister all scattered around the country. She is the second oldest and has some bitterness about having to take care of the other kids during her mother's illnesses or drunks. Her father was always apologetic about the responsibilities Natalie was left with and he would periodically break down in tears about this. Natalie sees herself as a strong and outspoken caretaker which is also apparent in her presentation. She feels she needs help either finding a way to get through to Darlene or facing the possibility that their relationship is over.

I move into some family of origin work around loss and illness to highlight her current crisis. She acknowledges some amount of grief and fear but keeps her attention focused on her lover's problems. At this point I suggest couples work.

The couples work lasted three months prior to and following Natalie's surgery. The work focused on the individual expression of feelings (at this point, Darlene could identify a few). We worked away from either polarized or identical feelings. I had to heavily coach them to not take away each other's feelings or to criticize or to negate feelings. Basically we made room in the relationship for Darlene's feelings. Natalie had become their voice, their decision maker, their social organizer--their extroverted, healthier self. Darlene had become their recluse, their sorrow and sadness, their hurt-their abused and neglected child. Each one had to take responsibility for their own totality and not allow the other one to pick up the slack. We reassigned roles, encouraged separate activities and friendships and made it okay to be articulate or quiet. Each one experimented with being more like the other one until a balance was struck.

A renewed warmth and closeness developed between them and they began to be more self satisfied. They came through the medical crisis just fine and seemed to enjoy the possibility that they could have

moments of bonding mixed with moments of autonomy. Natalie developed greater comfort with her autonomy and Darlene learned to enjoy closeness.

CASE EXAMPLE #2

Grace phoned me saying that she and her lover, Sally, had been referred to me for couples work by another therapist who was working individually with Sally. We set up an initial appointment to discuss treatment possibilities.

My first diagnostic clue about this couple was that they chose to sit in two separate chairs rather than on the couch. The hostility and pain between them was apparent right away. I began by asking each woman to describe how she saw their problems and how therapy might be helpful. Sally, the identified "therapy pro", began by stating that they have nothing in common although they had spent the last 2 years in a relationship. The crux of their fights was that Grace wanted affection and sex more frequently than Sally felt it. Sally described herself as "not very touchy-feely with a low sex drive". She was at my office to get help with their break-up.

Grace's story was quite different. Although she agreed that they don't have much in common, they really have something special. It was true that Grace required more physical contact but she explained that it was because of what she needed after getting home from work to unwind and be free of stress and tension. She claimed she really loved Sally and was in my office hoping that therapy would help their relationship. She did not want to break-up.

This is the background information I got from them. Sally is 35 years old and works for the water company in her town as a laborer. She is "out" with her co-workers and family and gets quite a bit of acceptance. She comes from a large family that she describes as "close although we don't talk to each other much". Her father left her mother when Sally was quite young and her mother remarried. She describes herself as "not too bright, not too educated but a lot of fun to be with. I have a lot of friends". Grace is 38 years old and is an architectural engineer in a very small but busy, all male company. She has to travel frequently for her job which she hates. She describes herself as "a homebody...would be happy to be a housewife--cooking, cleaning, organizing and taking care of pets". She is not "out" to her co-workers or her family who she says she is very close to. Sally is not comfortable with Grace's family and Grace is not comfortable with Sally's family.

The crisis that prompted the couples therapy was Sally telling Grace she wanted to leave the relationship. Grace was frightened and skeptical of therapy but was willing to try anything at this point to save the relationship.

We met for a total of 4 sessions. At the end of the first session I gave them my candid appraisal of their situation. I explained that they wanted different things in the treatment as well as their relationship. I told them I was very struck by their lack of

responses to by simple question "Why do you love her?". I was very unclear about what drew them together in the first place and what it was that kept them hanging on. In the remaining sessions I illuminated how they kept things in balance through their dichotomies and that was why they stayed together. Both women were very firm in their stances--pointing the finger at the other one and not wanting to change anything about their own selves. I declared it a stalemate and described two options they had. One was to continue in the relationship as it is--which they can both obviously tolerate pretty well. Or they could break-up and face the inevitable loss and pain that would be there.

During the last session we had, Sally took a firm stand that she wanted to end the relationship. And so they spent that session strategizing about how that would look. In consultation with Sally's individual therapist I learned that the separation was short-lived initially. Sally and Grace went back and forth about their separation several times before they actually severed their ties. The final blow came when Sally expressed her interest in another woman.

SUMMARY

Working with fused lesbian couples can be very challenging and rewarding work for a therapist. If you approach the treatment with certain assumptions of health and potential for growth, many couples have the opportunity to flourish individually while remaining with their lover. Perceiving the couple within the contexts of the heterosexual society, the gay subculture and their families of origin offers a broad systemic approach to this work.

Lesbians who have a tendency towards fusion in their primary relationships are usually women who have not yet individuated from their families of origin. These two developmentally immature women join together and create a cycle of fusion moving through six phases: Ecstacy, Marriage, Routine, Depression, Conflict and Ecstacy Revisited. Understanding these stages within the context of the gay subculture can help guide the clinical interventions.

With a thorough understanding of the various dynamics in play for the couple, there is every reason to be optimistic about the outcome of the treatment. The sooner the couple comes for help, the more likely they will be to successfully individuate while sustaining and improving their relationship. The later in the cycle the couple presents for treatment, the more dismal the prognosis is. Regardless of how long a couple remains in treatment, you still have an important opportunity to educate the women about their potential for mental health.